From:	David Heineck
To:	Boyd, Andrew; Lizanne Davis; Robert Forbes; rschoof@environcorp.com; Bill Bacon; Danny Stone ; non-responsive tamartin@sbtribes.com; susanh non-responsive non-responsive
Cc:	David Hoel; Dominik Alexander; Eng, Sharon
Subject:	RE: Fort Hall update - FMC
Date:	Monday, January 05, 2015 7:26:30 PM

Liz et al:

The week of January 26 for a conference call on the draft final report also works for me. Thanks.

Dave

From: Boyd, Andrew [mailto:Boyd.Andrew@epa.gov]
Sent: Monday, January 05, 2015 11:21 AM
To: Lizanne Davis; Robert Forbes; David Heineck; rschoof@environcorp.com; Bill Bacon; Danny Stone non-responsive tamartin@sbtribes.com; susanh non-responsive non-responsive
Cc: David Hoel; Dominik Alexander; Eng, Sharon
Subject: RE: Fort Hall update - FMC

That week works for me, except Friday 1/30 when I'll be traveling

---

From: Lizanne Davis [mailto:Lizanne.Davis@fmc.com]
Sent: Monday, January 05, 2015 9:38 AM
To: Robert Forbes; David Heineck; rschoof@environcorp.com; Bill Bacon; Danny Stone non-responsive tamartin@sbtribes.com; susanh non-responsive non-responsive Boyd, Andrew
Cc: David Hoel; Dominik Alexander
Subject: FW: Fort Hall update

Dear All,
Below is a status report on the SEP 14 project. We should expect to receive the draft report within approximately 2 weeks. I would like to then schedule a SMT call with David Hoel and Dominik Alexander a week from receipt which would be the week of January 26. Please let me know any dates that do not work for you during that week.
Best,
Liz

Lizanne H. Davis
Director, Government Affairs
FMC Corporation
1050 K Street, NW
Suite 600
Washington, DC 20001

202.956.5211 (Office), **202.412.1055** (Cell)
202.956.5235 (Fax)

lizanne.davis@fmc.com

From: Dominik Alexander [mailto:dalexander@epidstat.com]
Sent: Friday, December 19, 2014 11:46 AM
To: Lizanne Davis; David Hoel
Subject: Fort Hall update

Dear Liz,

We have made significant progress in the analytical phase of the Fort Hall community health assessment. According to the approved study work plan, we will evaluate the feasibility to conduct four health assessments (i.e., cancer, mortality, sentinel events, and asthma), and we will carry out the analyses for each of the four assessments if feasible and scientifically relevant.

1. Cancer: The basis of assessing cancer risks involves the concept of disease rates, which are the numbers of cancer occurrences that are observed in a given in a population of a specified size. Specifically, cancer incidence is a measure of disease burden that describes the occurrence of new cancer cases in a given study population in a given time period. The Centers for Disease Control (CDC) of the Public Health Service provides support to most of the State Cancer Registries. Besides helping to maintain the registries, the CDC sees that the data is of a high quality through the National Program of Cancer Registries (NPCR), which was established in 1992. Idaho's Registry began in 1979 and joined the NPCR program in 1994. The North American Association of Central Cancer Registries (NAACCR) is an oversight group that began in 1987. Data down to the county level began in 1995 and the NAACCR provides certification for the quality of a State's data. The registries have three levels of certification with gold being the highest. The Idaho Registry has received a gold rating every year since this rating system began. In an ideal setting, and to increase study validity, data should be ascertained at the most specific level as possible. As indicated, most cancer data are readily available at the County-level. However, through the extensive work of Chris Johnson, who is an epidemiologist in charge of the Idaho Cancer Registry, his geo-coding of cancer cases and the availability of U.S. census data at the census tract level during the period 2007-2011 has facilitated a cancer incidence analysis of the highest quality at the community level. However, cancer incidence data extending back to the 1990s is not expected to be geocoded until mid-2015. Despite this, the cancer data available for the years 2007-2011 is of high quality and reflects the long latency periods typical of cancer etiology.
2. Mortality: The National Center for Health Statistics (NCHS) of the CDC collects and codes all death certificates in the United States. This data coupled with data from the census bureau then provides mortality rates for various causes of mortality. The data are available by location, age, race, gender etc. Using this data, one can estimate and compare mortality rates for a given cause of death by age, gender, race etc. The data are publically available through the CDC internet site. Thus, rates of causes of death can be compared between the Fort Hall counties and the remainder of Idaho, or selected comparison counties. Although these data are not geocoded, this is standard methodological practice to evaluate the mortality experience in a community. This analytical methodology is in concert with hundreds of scientific publications on community health assessments.
3. Sentinel Events: In epidemiologic parlance, sentinel events involve the occurrence of a rare disease known to be associated with a specific exposure. These disease occurrences are typically identified through a framework of surveillance networks over a lengthy time period.

In the current Fort Hall community health assessment, we have to rely upon the identification of greater than expected occurrences of certain cancer outcomes or causes of death in our analyses to determine whether an outcome may be classified as unique to the specific Fort Hall community setting. Thus, given our current methodological and analytical protocol, the occurrence of an excess number of specific cancer cases or causes of death will be identified concurrently with our cancer and mortality studies.

4. Asthma: This health condition is the most challenging to evaluate for a number of reasons. A few of these challenges are as follows: 1) there is no county, community, or state registry for the identification and collection of asthma cases, thus, we have no existing and publicly available repository for validated data to conduct a systematic analysis; 2) the diagnosis of asthma is highly variable, and is often subjective in terms of incidence classification, thus, complicating interpretation of data; 3) in the absence of publicly available registry data, it would be necessary to ascertain individual-level medical information from the entire study catchment area in Fort Hall; and 4) we attempted to ascertain the willingness to participate in a community health study (sending over a thousand questionnaires) and feedback was well below acceptable limits, and the response of sharing medical information was unacceptably low. Thus, the only relevant and feasible endeavor (although of limited scientific validity) would be to compare visits pertaining to asthma before and after plant closure (as discussed with the Study Design Panel). However, this would require a health liaison from the Fort Hall community and participation from the clinic in Fort Hall. We have made efforts to reach out to staff to pursue this option, however, feedback was limited and it appears as though medical record storage is variable (electronic vs. written). Therefore, it is not reasonable to pursue any additional analytical ventures for asthma at this time.

David has reviewed this memo and agrees to its content.

Sincerely,
Dominik

Dominik D Alexander, PhD, MSPH
Principal Epidemiologist

EpidStat Institute
Office: 303-670-6734
Mobile: 630-390-8190
dalexander@epidstat.com